

MONTANA LEGISLATIVE HISTORY

Chapter 173 1995

Bill H _____ S 177 Original bill & history ✓ c

H. Committee on	<u>Business</u> ^{Lebor} Industry	S. Committee on	<u>Business</u> ^{Industry} Lebor
Hearing Date(s)	<u>1/27</u> _____ c	Hearing Date(s)	<u>3/6</u> _____ c
	<u>3/03</u> <u>✓</u> c		<u>1/27</u> <u>✓</u> c
	_____ c		_____ c
	_____ c		_____ c
Date Out	_____ c		

Did this bill originate in an interim committee? ____ Yes ____ No

Committee _____

Report _____

SB 175 INTRODUCED BY VAN VALKENBURG
 PROVIDE IMMUNITY FROM PROSECUTION FOR STATEMENTS MADE BY
 PERSONS PARTICIPATING IN SEXUAL OFFENDER TREATMENT
 PROGRAMS AFTER CONVICTIONS FOR SEXUAL OFFENSES

1/17	INTRODUCED		
1/17	FIRST READING		
1/17	REFERRED TO JUDICIARY		
1/24	HEARING		
1/24	COMMITTEE REPORT—BILL PASSED		
1/25	2ND READING PASSED	41	9
1/26	3RD READING PASSED	39	10
	TRANSMITTED TO HOUSE		
1/27	FIRST READING		
1/27	REFERRED TO JUDICIARY		
3/09	HEARING		
3/09	TABLED IN COMMITTEE		
	DIED IN COMMITTEE		

SB 176 INTRODUCED BY JERGSON, ET AL.
 REDUCE GASOLINE AND SPECIAL FUELS TAXES 5 CENTS PER GALLON

1/17	INTRODUCED		
1/17	FIRST READING		
1/17	REFERRED TO TAXATION		
1/18	FISCAL NOTE REQUESTED		
1/21	FISCAL NOTE RECEIVED		
1/21	FISCAL NOTE PRINTED		
1/27	HEARING		
3/09	TABLED IN COMMITTEE		
3/23	MOTION FAILED TO TAKE FROM COMMITTEE AND PLACE ON 2ND READING	22	28
3/29	MISSED TRANSMITTAL DEADLINE FOR 71ST DAY DIED IN COMMITTEE		

SB 177 INTRODUCED BY FOSTER
 REQUIRE DISABILITY INSURERS, HEALTH SERVICE CORPORATIONS, AND
 HEALTH MAINTENANCE ORGANIZATIONS TO DISCLOSE THE MEANING
 OF CERTAIN TERMS

✓1/17	INTRODUCED		
1/17	FIRST READING		
1/17	REFERRED TO BUSINESS & INDUSTRY		
✓1/27	HEARING		
2/08	COMMITTEE REPORT—BILL PASSED AS AMENDED		
2/09	2ND READING PASSED	49	0
2/10	3RD READING PASSED	49	0
	TRANSMITTED TO HOUSE		
2/13	FIRST READING		
2/15	REFERRED TO BUSINESS & LABOR		
✓3/03	HEARING		
3/03 +	COMMITTEE REPORT—BILL CONCURRED		
3/06	2ND READING CONCURRED AS AMENDED	99	1
3/08	3RD READING CONCURRED	99	1
	RETURNED TO SENATE WITH AMENDMENTS		
3/10	2ND READING AMENDMENTS CONCURRED	43	0
3/11	3RD READING AMENDMENTS CONCURRED	38	1
3/15	SIGNED BY PRESIDENT		
3/15	SIGNED BY SPEAKER		
3/16	TRANSMITTED TO GOVERNOR		

3/20 SIGNED BY GOVERNOR
 CHAPTER NUMBER 173
 EFFECTIVE DATE: 10/01/95

SB 178 INTRODUCED BY JENKINS

REQUIRE THAT ELECTIONS FOR COUNTY AND MUNICIPAL OFFICES,
 EXCEPT ELECTIONS FOR COUNTY COMMISSIONERS, BE CONDUCTED
 ON A NONPARTISAN BASIS

1/18 INTRODUCED
 1/18 FIRST READING
 1/18 REFERRED TO LOCAL GOVERNMENT
 1/31 HEARING
 1/31 TABBED IN COMMITTEE
 2/23 MISSED TRANSMITTAL DEADLINE FOR 45TH DAY
 DIED IN COMMITTEE

SB 179 INTRODUCED BY WILSON, ET AL.

INCREASE MINIMUM HOURLY WAGE RATE FOR CERTAIN EMPLOYEES TO
 \$5 AN HOUR OR THE RATE SET UNDER FEDERAL LAW, WHICHEVER IS
 GREATER

1/18 INTRODUCED
 1/18 FIRST READING
 1/18 REFERRED TO LABOR & EMPLOYMENT RELATIONS
 1/19 FISCAL NOTE REQUESTED
 1/23 FISCAL NOTE RECEIVED
 1/23 FISCAL NOTE PRINTED
 2/07 HEARING
 2/10 TABBED IN COMMITTEE
 2/10 MOTION FAILED TO TAKE FROM COMMITTEE
 AND PLACE ON 2ND READING
 2/23 MISSED TRANSMITTAL DEADLINE FOR 45TH DAY
 DIED IN COMMITTEE

23 27

SB 180 INTRODUCED BY TVEIT, ET AL.

CLARIFY THE BINDING SCHOOL ARBITRATION PROVISION IN A
 COLLECTIVE BARGAINING AGREEMENT WITH A SCHOOL

1/18 INTRODUCED
 1/18 FIRST READING
 1/18 REFERRED TO EDUCATION & CULTURAL RESOURCES
 1/19 REREFERRED TO LABOR & EMPLOYMENT RELATIONS
 2/02 HEARING
 2/09 COMMITTEE REPORT—BILL PASSED
 2/10 2ND READING DO PASS MOTION FAILED
 2/10 2ND READING INDEFINITELY POSTPONED

19 30
 32 17

SB 181 INTRODUCED BY WELDON, ET AL.

REVISE THE DEFINITION OF "UNZONED COMMERCIAL OR INDUSTRIAL
 AREA" AS APPLIED TO OUTDOOR ADVERTISING
 BY REQUEST OF THE DEPARTMENT OF TRANSPORTATION

1/18 INTRODUCED
 1/18 FIRST READING
 1/18 REFERRED TO HIGHWAYS & TRANSPORTATION
 1/19 FISCAL NOTE REQUESTED
 1/25 FISCAL NOTE RECEIVED
 1/26 FISCAL NOTE PRINTED
 2/02 HEARING
 2/07 COMMITTEE REPORT—BILL PASSED AS AMENDED

SENATE BILL NO. 177

INTRODUCED BY

Foster

A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING INSURANCE PRODUCERS AND HEALTH MAINTENANCE ORGANIZATIONS TO DISCLOSE THE MEANING OF CERTAIN TERMS AND PROVIDE AN EXPLANATION OF CHARGES; AND AMENDING SECTION 33-31-301, MCA."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. Section 1. Explanation of charges. (1) A policy, subscriber contract, or certificate that provides for the payment of benefits based on standards described as usual and customary, reasonable and customary, prevailing fee, allowable charges, or relative value schedule and that is issued or issued for delivery in this state or renewed, extended, or modified on or after October 1, 1995, must include in plain language an explanation of:

(a) how the insurance producer calculates the amounts that it determines to be usual and customary, reasonable and customary, prevailing fee, allowable charges, or relative value schedule;

(b) the sources of data used to make the determinations in subsection (1)(a);

(c) the size and location of the geographic area considered in making the determination in subsection (1)(a);

(d) the possible balance of charges to be paid by the insured; and

(e) how the insurance producer determines that a provider's charges are unreasonable.

(2) An insurance producer shall provide to the policyholder and to the health care provider, as defined in 33-9-101, the same explanation required in subsections (1)(a) through 1(e) when claims are processed.

Section 2. Section 33-31-301, MCA, is amended to read:

"33-31-301. Evidence of coverage -- schedule of charges for health care services. (1) ~~Every~~ Each enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance policy issued by an insurer or a contract issued by a health service corporation, whether by option or

1 otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

2 (2) A health maintenance organization may not issue or deliver an enrollment form, an evidence
3 of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this
4 state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved
5 enrollment form or evidence of coverage is filed with and approved by the commissioner.

6 (3) An evidence of coverage issued or delivered to a person resident in this state may not contain
7 a provision or statement that is untrue, misleading, or deceptive as defined in 33-31-312(1). The evidence
8 of coverage must contain:

9 (a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate,
10 of:

11 (i) the health care services and the insurance or other benefits, if any, to which the enrollee is
12 entitled;

13 (ii) any limitations on the services, kinds of services, or benefits to be provided, including any
14 deductible or copayment feature;

15 (iii) the location at which and the manner in which information is available as to how services may
16 be obtained;

17 (iv) the total amount of payment for health care services and the indemnity or service benefits, if
18 any, that the enrollee is obligated to pay with respect to individual contracts; and

19 (v) a clear and understandable description of the health maintenance organization's method for
20 resolving enrollee complaints;

21 (b) definitions of geographical service area, emergency care, urgent care, out-of-area services,
22 dependent, and primary provider, if these terms or terms of similar meaning are used in the evidence of
23 coverage and have an effect on the benefits covered by the plan. The definition of geographical service area
24 need not be stated in the text of the evidence of coverage if the definition is adequately described in an
25 attachment that is given to each enrollee along with the evidence of coverage.

26 (c) clear disclosure of each provision that limits benefits or access to service in the exclusions,
27 limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and
28 exceptions that must be disclosed include but are not limited to:

29 (i) emergency and urgent care;

30 (ii) restrictions on the selection of primary or referral providers;

1 (iii) restrictions on changing providers during the contract period;

2 (iv) out-of-pocket costs, including copayments and deductibles;

3 (v) charges for missed appointments or other administrative sanctions;

4 (vi) restrictions on access to care if copayments or other charges are not paid; and

5 (vii) any restrictions on coverage for dependents who do not reside in the service area;

6 (d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease
7 treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and
8 nervous and mental disorders;

9 (e) a provision requiring immediate accident and sickness coverage, from and after the moment of
10 birth, to each newborn infant of an enrollee or ~~his~~ the enrollee's dependents;

11 (f) a provision requiring medical treatment and referral services to appropriate ancillary services for
12 mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits and
13 coverage provided in Title 33, chapter 22, part 7; however:

14 (i) after the primary care physician refers an enrollee for treatment of and appropriate ancillary
15 services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit
16 the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary
17 services for mental illness, alcoholism, or drug addiction;

18 (ii) if an enrollee chooses a provider other than the health maintenance organization provider for
19 ~~such~~ treatment and referral services, the enrollee's designated provider ~~must~~ shall limit ~~his~~ treatment and
20 services to the scope of the referral in order to receive payment from the health maintenance organization;

21 (iii) the amount paid by the health maintenance organization to the enrollee's designated provider
22 may not exceed the amount paid by the health maintenance organization to one of its providers for
23 equivalent treatment or services;

24 (g) a provision as follows:

25 "Conformity With State Statutes: Any provision of this evidence of coverage that on its effective
26 date is in conflict with the statutes of the state in which the insured resides on that date is hereby amended
27 to conform to the minimum requirements of those statutes."

28 (h) a provision that the health maintenance organization shall issue, without evidence of
29 insurability, to the enrollee, ~~or his~~ the enrollee's dependents, or family members continuing coverage on
30 the enrollee, ~~his~~ dependents, or family members:

1 (i) if the evidence of coverage or any portion of it on an enrollee, ~~his~~ or the enrollee's dependents,
2 or family members covered under the evidence of coverage ceases because of termination of employment,
3 ~~or because of his the enrollee's~~ membership in the class or classes eligible for coverage under the policy,
4 or because ~~his~~ the enrollee's employer discontinues ~~his~~ business or the coverage;

5 (ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months
6 preceding the termination of group coverage; and

7 (iii) if the enrollee applied for continuing coverage within 31 days after the termination of group
8 coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by
9 the group contract from which the enrollee converts.

10 (i) a provision that clearly describes the amount of money an enrollee shall pay to the health
11 maintenance organization to be covered for basic health care services;

12 (j) definitions for terms that limit payment of health care services based on standards described as
13 usual and customary, reasonable and customary, prevailing fee, allowable charges, or a relative value
14 schedule and an explanation of the charges as provided in [section 1].

15 (4) A health maintenance organization may amend an enrollment form or an evidence of coverage
16 in a separate document if the separate document is filed with and approved by the commissioner and issued
17 to the enrollee.

18 (5) (a) A health maintenance organization shall provide the same coverage for newborn infants,
19 required by subsection (3)(e), as it provides for enrollees, except that for newborn infants there may be no
20 waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce
21 benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is
22 consistent with the deductible or reduction in benefits applicable to all covered persons.

23 (b) A health maintenance organization may not issue or amend an evidence of coverage in this
24 state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and
25 sickness coverage or insurability of newborn infants of an enrollee or ~~his~~ the enrollee's dependents from
26 and after the moment of birth.

27 (c) If a health maintenance organization requires payment of a specific fee to provide coverage of
28 a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain
29 a provision that requires notification to the health maintenance organization, within 31 days after the date
30 of birth, of the birth of an infant and payment of the required fee.

1 (6) A health maintenance organization may not use a schedule of charges for enrollee coverage for
2 health care services or an amendment to a schedule of charges before it files a copy of the schedule of
3 charges or the amendment to it with the commissioner. A health maintenance organization may evidence
4 a subsequent amendment to a schedule of charges in a separate document issued to the enrollee. The
5 charges in the schedule must be established in accordance with actuarial principles for various categories
6 of enrollees, except that charges applicable to an enrollee ~~must~~ may not be individually determined based
7 on the status of ~~his~~ the enrollee's health.

8 (7) The commissioner shall, within 60 days, approve a form if the requirements of subsections (1)
9 through (5) are met. A health maintenance organization may not issue a form before the commissioner
10 approves the form. ~~If the~~ The commissioner ~~disapproves the filing, he~~ shall notify the filer of a disapproved
11 filing. In the notice, the commissioner shall specify the reasons for ~~his~~ disapproval. The commissioner shall
12 grant a hearing within 30 days after ~~he receives~~ receiving a written request by the filer.

13 (8) The commissioner may ~~in his discretion~~ require a health maintenance organization to submit
14 any ~~relevant~~ information ~~he considers necessary in~~ relevant to determining whether to approve or
15 disapprove a filing made pursuant to this section."
16

17 **NEW SECTION. Section 3. Codification instruction.** [Section 1] is intended to be codified as an
18 integral part of Title 33, chapter 15, and the provisions of Title 33, chapter 15, apply to [section 1].

19 -END-

MINUTES

**MONTANA SENATE
54th LEGISLATURE - REGULAR SESSION
COMMITTEE ON BUSINESS & INDUSTRY**

Call to Order: By CHAIRMAN JOHN HERTEL, on January 27, 1995, at
8:00 a.m.

ROLL CALL

Members Present:

Sen. John R. Hertel, Chairman (R)
Sen. Steve Benedict, Vice Chairman (R)
Sen. William S. Crismore (R)
Sen. C.A. Casey Emerson (R)
Sen. Ken Miller (R)
Sen. Mike Sprague (R)
Sen. Gary Forrester (D)
Sen. Terry Klampe (D)
Sen. Bill Wilson (D)

Members Excused: N/A

Members Absent: N/A

Staff Present: Bart Campbell, Legislative Council
Lynette Lavin, Committee Secretary

Please Note: These are summary minutes. Testimony and
discussion are paraphrased and condensed.

Committee Business Summary:

Hearing: SB 177
Executive Action: HB 54 BE CONCURRED IN AS AMENDED
SB 164 TABLED

HEARING ON SB 177

Opening Statement by Sponsor:

SEN. MIKE FOSTER, SD 20, Townsend, stated that SB 177 is a pro-consumer bill that requires full disclosure. This is an issue that has arisen recently as a result of the confusion of some health insurance policy holders. The bill relates to health care insurers only. **SEN. FOSTER** explained that when a person buys a health insurance policy that policy may state that the insurance company is going to pay a certain percent of what is deemed as reasonable and customary charges. This means that whatever the health care provider charges, the insurance company will pay a certain percentage of what they deem reasonable and customary.

The reason this has become a problem is the policy holder goes to a health care provider for a specific treatment, when the bill comes the policy holder thinks the insurance company will pay the stated percentage of the total bill. However, what happens is the insurance company sends the bill back to the policy holder stating they are paying the stated percentage of what they deem the reasonable and customary charge for that service. The end result is a policy holder who is upset because they don't understand why the insurance will not pay the stated percentage of the total bill. The policy holder wonders if their health care provider is charging too much. There are reports of the insurance companies saying the health care providers are charging unreasonable rates for the particular service. The result is providers arguing that their rates are not unreasonable.

SEN. FOSTER stated the purpose of the bill is to require insurance companies to provide full disclosure and explain to the policy holder what reasonable and customary really means. He explained there were some serious problems in the bill drafting. SB 177 must be amended considerably in order to work. He gave the committee a set of amendments, **EXHIBIT 1**. The amendments are a result of working with the Insurance Commissioners Office and the insurance industry itself to figure out language that will make the bill work and not be overly burdensome to the insurance industry. Placing too much of a burden on the insurance companies could result in an increase of the cost of premiums.

Basically the bill says insurance companies must tell people up front what reasonable and customary means. From that point, if a policy holder has a complaint and feels the insurance company didn't pay what they should then the policy holder can call the Insurance Commissioner's Office and file a complaint. The Insurance Commissioner's Office can investigate and require the insurance company to explain their process of determining reasonable and customary charges for the particular service. A health care provider also has the right to go to the Commissioner and request an explanation for the difference between what he is charging and what the insurance company views as reasonable and customary. This is a pro-consumer, full disclosure bill.

Proponents' Testimony:

Frank Cote, Deputy Insurance Commissioner, State Auditor's Office, urged support of SB 177 as amended. He stated the State Auditor's Office would like the title of the bill amended to read on line 4 "disability insurers, health service corporations and health maintenance organization" instead of "insurance producers". He declared that SB 177 truly is a consumer bill. It allows consumers an opportunity to understand the language used by insurance companies. This is an appropriate and good change.

Gregory VanHorsen, State Farm Insurance, explained that when the bill was originally drafted they had some concerns about it.

Those concerns were addressed in the amendments mentioned in the sponsors opening statement and the amendments proposed by **Mr. Cote**, making the bill apply exclusively to health insurance policies. **Mr. VanHorssen** proposed an amendment making the language clear that the sole focus of the bill is the disability policies.

Tom Hopgood, Health Insurance Association of American, explained he and **SEN. FOSTER** did research last year on this issue to determine what the problem was. They concluded there was a big problem. They do support this bill as amended, and believe SB 177 will help.

Larry Akey, Montana Association of Life Underwriters, stated they represent the agents on the front lines. They opposed the bill, as introduced, because of the language in the bill. As the sponsor has proposed amending the bill, they support it. He thanked **SEN. FOSTER** for making the bill a workable piece of legislation so it will not be a hardship on the insurance companies.

Jerry Loendorf, Montana Medical Association, stated that the bill will provide language so that a person who buys a policy can know what they are getting. This would help to prevent a person from buying a policy believing they are getting one thing and realizing when the bill arrives that they didn't get what they thought. The Montana Medical Association generally supports the concept of SB 177.

Jacqueline Lenmark, American Insurance Association, expressed support for the bill as amended.

Tanya Ask, Blue Cross/Blue Shield of Montana, stated support for the bill as amended.

Denny Moreen, American Council of Life Insurance, expressed support for the bill as amended.

Arlette Randash, Eagle Forum, representing families across Montana, stated that they applaud **SEN FOSTER'S** efforts to clarify language and make it easier for laymen to understand insurance. She said that the most aggravating situation for families is not being able to understand policies.

Mike Craig, Montana Health Care Authority, stated support for SB 177.

Opponents' Testimony: None.

Informational Testimony: none.

Questions From Committee Members and Responses:

SEN. KEN MILLER asked SEN. FOSTER if the amendment provided for everything from page 1, line 10 through page 4, line 11 to be stricken. SEN. FOSTER explained that they had experienced severe bill drafting problems. He is not an expert in insurance and the problems, to a degree, his fault due to ignorance in the area of insurance technicalities. The insurance industry and the Insurance Commissioner's Office came to his aid and suggested amendments to accomplish his goals in a workable way.

SEN. STEVE BENEDICT asked SEN. FOSTER to work with Mr. VanHorrssen and Mr. Cote to get a full set of amendments and a gray bill for the committee for executive action to save Mr. Campbell some time. SEN. FOSTER apologized for the confusion and stated that it was unintentional.

SEN. GARY FORRESTER asked SEN. FOSTER why the insurance industry objected to writing language that consumers could understand on all policies instead of just the area of disability and health insurance. Why did the bill only apply to just one area? SEN. FOSTER stated he could not answer that and referred the question to Mr. Cote. Mr. Cote replied that in a previous session life and health insurers were required to write their policies in plain English. In the 1993 session a bill was passed requiring property and casualty insurers, as of April 1, 1996, to write their policies in plain English. He also explained that Mr. Moreen and he discussed excluding insurers besides disability insurers because the language of the bill does not apply to the other insurers. For example, life insurers, there is no definition for usual and customary death.

Closing by Sponsor:

SEN. FOSTER asked the committee for patience in working on this bill. His goal is to help the consumers of Montana. He thanked all the people who made the bill workable and stated it would be a shame to lose the bill just because it didn't make any sense.

Discussion:

SEN. BENEDICT referred to the committee bills in drafting and stated that Bart Campbell had completed the drafting of one of the committee bills. He noted the only problem with the bill now that it was drafted was the fact it needed to be heard in the Judiciary Committee. SEN. BENEDICT explained that if the committee did not object, Mr. Campbell would send a letter to the Chairman of the Judiciary Committee stating that the bill is ready. The Judiciary Chairman would then ask that it be assigned a bill number and sent through the process. When it comes up on first reading on the Senate floor, the members of the committee would then ask to have it transferred to the Judiciary Committee.

AMENDMENT OF SENATE BILL 177

DATE
#1
1-27-95
SB 177
BILL NO.

Introduced by Senator Foster 1/20/95

SB 177, INTRODUCED BILL, BE AMENDED AS FOLLOWS:

(1) Amend title

1. Title, page 1, lines 4-6.

Following: "AN ACT REQUIRING" on line 4

Strike: "INSURANCE PRODUCERS"

Insert: "INSURERS, HEALTH SERVICE CORPORATIONS"

2. Title, page 1, line 6-7.

Following: "DISCLOSE THE MEANING OF CERTAIN TERMS"

Strike: "AND PROVIDE AN EXPLANATION OF CHARGES; AND
AMENDING SECTION 33-31-301, MCA."

(2) Insert material following stricken material

1. Page 1, line 10.

Following: "Explanation of charges (1)."

Strike: [All of the material through page 4, line 11.]

Insert: "a disability insurer, health service
corporation, and health maintenance
organization which issues policies or which
issues policies for delivery in this state or
which renews, extends, or modifies policies
on or after October 1, 1995, shall include in
the policies:"

2. Page 4, line 14.

Following: "relative value schedule"

Strike: "and an explanation of the charges as
provided in [section 1]."

3. Page 4, line 15: [Delete all material through
page 5, line 15.]

SENATE JOURNAL
THIRTY-THIRD LEGISLATIVE DAY - FEBRUARY 8, 1995

And, as amended, do pass. Report adopted.

SB 275, introduced bill, be amended as follows:

1. Page 1, line 20.

Strike: "\$5,000"

Insert: "\$3,000"

Following: "stock"

Insert: "and that submits a notarized affidavit to that effect to the department"

2. Page 1, line 21.

Strike: "\$25"

Insert: "\$30"

3. Page 1, line 22.

Strike: "\$5,000"

Insert: "\$3,000"

And, as amended, do pass. Report adopted.

SB 289, introduced bill, do pass. Report adopted.

HB 170, be concurred in. Report adopted.

BUSINESS & INDUSTRY (Hertel, Chairman):

February 8, 1995

SB 177, introduced bill, be amended as follows:

1. Title, line 4.

Strike: "INSURANCE PRODUCERS"

Insert: "DISABILITY INSURERS, HEALTH SERVICE CORPORATIONS,"

2. Title, lines 5 and 6.

Strike: "AND" on line 5 through "MCA" on line 6

3. Page 1, lines 10 through 24.

Strike: "(1)" on line 10 through "processed" on line 24

Insert: "A disability insurer, health service corporation, or health maintenance organization that issues policies, certificates, or contracts, that issues policies, certificates, or contracts for delivery in this state, or that renews, extends, or modifies policies, certificates, or contracts on or after October 1, 1995, shall include in the disability policies, certificates, or contracts definitions for terms that limit payment of health care services based on standards described as usual and customary, reasonable and customary, prevailing fee, allowable charges, or a relative value schedule"

4. Page 1, line 26 through page 5, line 15.

Strike: Section 2 in its entirety

Renumber: subsequent section

And, as amended, do pass. Report adopted.

DATE

SENATE COMMITTEE ON

BILLS BEING HEARD TODAY:

January 27, 1995

Business and Industry

SB 177

Senator Mike Foster

< ■ >

PLEASE PRINT

< ■ >

Check One

Name	Representing	Bill No.	Support	Oppose
Jacqueline Denmark	Am. Ins. Assoc.	177		X
B. V. Whelan	State Farm Ins	177	X	✓
Greg Van Housen	State Farm	177	X	
LARRY AKET	MT ASSOC OF LIFE UNDERWRITERS		AS AMENDED	
Milco Craig	MT Health Care Assn	177	✓	
Arlette Bendish	Eagle Forum	"	"	
Laurie Koatnick	Christian Coalition	"	✓	
Tanya Bzik	Bla Cross + Blue Shield	"	✓	45 min.
Tony Hopwood	HIAA	"	✓	
Paul Costo	St. Aud. Tor	177	Amend	
James Loendorf	Alk. Med Assn	177	✓	
Denny Molen	ACLI	177	✓	

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

MINUTES

**MONTANA HOUSE OF REPRESENTATIVES
54th LEGISLATURE - REGULAR SESSION**

COMMITTEE ON BUSINESS & LABOR

Call to Order: By **CHAIRMAN BRUCE T. SIMON**, on March 3, 1995, at 8:00 AM.

ROLL CALL

Members Present:

Rep. Bruce T. Simon, Chairman (R)
Rep. Norm Mills, Vice Chairman (Majority) (R)
Rep. Robert J. "Bob" Pavlovich, Vice Chairman (Minority) (D)
Rep. Vicki Cocchiarella (D)
Rep. Charles R. Devaney (R)
Rep. Jon Ellingson (D)
Rep. Alvin A. Ellis, Jr. (R)
Rep. David Ewer (D)
Rep. Rose Forbes (R)
Rep. Jack R. Herron (R)
Rep. Bob Keenan (R)
Rep. Don Larson (D)
Rep. Rod Marshall (R)
Rep. Jeanette S. McKee (R)
Rep. Karl Ohs (R)
Rep. Paul Sliter (R)
Rep. Carley Tuss (D)
Rep. Joe Barnett (R)

Members Excused: None.

Members Absent: None.

Staff Present: Stephen Maly, Legislative Council
Alberta Strachan, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:

Hearing: SB 216, SB 177, SB 228, SB 238, SB 242,
SB 22, SB 19
Executive Action: SB 177, SB 216, SB 201, SB 238, SB 228

HEARING ON SB 216

Opening Statement by Sponsor:

SEN. TOM BECK, SD 28, Powell County, said this bill was an act establishing continuing education requirements for credit life

Are there any ethical standards that apply to the issuance of credit life or disability insurance, in particular, reference to automobile dealers. **Mr. Turkiewicz** said the bill had been written for a credit life individual and would be a combination of five hours which would include credit life insurance law and ethics.

Closing by Sponsor:

The sponsor closed.

HEARING ON SB 177

Opening Statement by Sponsor:

SEN. MIKE FOSTER, SD 20, Broadwater County, said this bill was an act requiring insurance producers and health maintenance organizations to disclose the meaning of certain terms.

Proponents' Testimony:

Frank Coty, Deputy Insurance Commissioner, said they supported this bill. Their office receives many telephone calls from upset consumers and this bill will help those consumers better understand their policies and how the insurance company operates and alleviation of concerns.

Susan Good, Heal Montana, said this group is very much interested in cost containment and the transformation of individuals in the state from being just a patient to actual medical consumers. It is difficult for them to make informed choices without all of the necessary information. This bill will go a long way to make those benefits more understandable to the consumer so they can make better informed choices about their own health care.

REP. ALVIN ELLIS said he favored this bill. He then reiterated a family circumstance regarding insurance.

Tanya Ask, Blue Cross/Blue Shield of Montana, supported this bill.

John Fink, Montana Hospital Association, supported this bill as providers. Hospitals spend a considerable amount of their time in helping individuals who arrive at hospitals as patients. They solve their insurance problems and they feel this bill will alleviate those problems before they arrive at the Association.

Opponents' Testimony:

None.

Questions From Committee Members and Responses:

REP. NORM MILLS stated there was not a definition of terms. **Mr. Coty** said each and every company may have a different definition for reasonable and customary policy. That is the purpose of the bill.

REP. ELLIS asked if this bill will give the Insurance Commission much more ability in refereeing. Or, will it be refereed between the hospital and carrier. **Mr. Coty** said they were still the ultimate referee between the consumer and the insurance company. Hopefully, by having this in the bill the consumers will be able to better understand what is happening and better communicate with the insurance company and providers.

REP. ELLINGSON asked if the problem was that someone had purchased health insurance contracts which provide for payment of a certain percentage of the usual prevailing fees. The person who has those services done, the insurance company comes back and states their prevailing fee which they recognize and they pay that particular percentage. The health care provider has charged them something other than the prevailing fee. Is that the problem? **Mr. Coty** said yes.

REP. ELLINGSON said they were dealing with the understanding on the part of the consumer that they may be getting insurance, but they may be going to a health provider that charges something other than the prevailing fee. **Mr. Coty** said yes.

REP. ELLINGSON said this was a step in the right direction but there are some other things which could be done like no definition. There should be something which provides specific language which needs to be in every insurance contract that specifically warns a consumer of the prevailing issue which states the provider will pay a percentage of the fee but consumers should be aware because some of the hospitals and doctors will charge much more. **Mr. Coty** said he personally did not care if this was inserted nor would the insurance lobby object. Many would put that in the definition.

REP. CHARLES DEVANEY asked if some of insurers already take care of the above situation where they require policy holders to notify the insurance carrier prior to submitting to a procedure so an insurance company can make any type of recommendations they must make. **Mr. Coty** said in some cases this is correct. Some companies do have prior authorization before going into in-patient hospital care. This bill also deals with other objectives. Even they do have prior authorization. It does not always mean they are explaining to the client or consumer that the difference between their usual and customary charges and the charge the provider would supply may not be paid.

CHAIRMAN SIMON asked if it would be necessary for the Commission to adopt rules regarding implementation of this legislation. **Mr.**

Coty said implementation of rules would not be necessary because of the statutory nature of the act. Therefore they would be required. CHAIRMAN SIMON said rules would define. That would address the problem which REP. ELLINGSON commented on. They should tell people what the truth was. Mr. Coty said if the Commission was granted the rulemaking authority to implement the concerns this could be done.

Closing by Sponsor:

The sponsor closed.

EXECUTIVE ACTION ON SB 177

Motion: REP. ELLIS MOVED SB 177 BE CONCURRED IN.

Discussion:

REP. MILLS stated the method of setting charges is so different between different hospitals but this is not going to cure the problem. This bill is just going to narrow the problem down.

REP. VICKI COCCHIARELLA said she had a license to sell this type of insurance and this bill goes a long way in making it a much easier, consumer-friendly product to purchase. It is not necessary to have the language added to this bill and would not propose any amendments.

REP. ELLIS said he would not be in favor of any rulemaking authority and let the bill stand.

CHAIRMAN SIMON said he had asked the question to determine if there was rulemaking authority and the commission does not have it nor is it the intention of the committee to give rulemaking authority.

Vote: Motion carried 18-0.

EXECUTIVE ACTION ON SB 216

Motion/Vote: REP. JOE BARNETT MOVED SB 216 BE CONCURRED IN.
Motion carried 18-0.

EXECUTIVE ACTION ON SB 201

Motion: REP. ELLIS MOVED SB 201 BE CONCURRED IN. REP. ELLIS MOVED THE AMENDMENTS.

Vote: Motion carried to adopt the amendments 18-0.

Motion: REP. ELLIS MOVED SB 201 BE CONCURRED AS AMENDED.

HOUSE OF REPRESENTATIVES
VISITORS REGISTER

Business & Labor

DATE 3-3-95

BILL NO. SB 177 SPONSOR(S) _____

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NAME AND ADDRESS	REPRESENTING	Support	Oppose
Maguline Denmark	Am. Soc. Labor.	✓	
Thanya Abk	Blue Cross Blg. Shld	✓	
Frank Cote	St. Auditor	✓	
John Flink	MT Hosp. Assn	✓	
Tom Hopgood	Hlth Ins. Assn. America	✓	
Alvin Ellis Jr	Self	—	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.